STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN5405	A. BUILDING _____ B. WING _____	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ETOWAH HEALTH CARE CENTER	409 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments An annual survey and complaint investigation #27025 and #27888, were completed on April 18-20, 2011. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	5/20/11 4. The Dietary Manager will perform random checks at least 5 times per week of the temperature log and of the dish machine temperature prior to use for one month. After one month, the checks will be completed weekly for two months or until substantial compliance is achieved. The Dietary Manager will record the temperatures found on the random checks on a log. The log will also include random checks of employee hand washing and the cleanliness of the fan. 5. Any deficient practice will have corrective action taken at time of discovery. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Dietary Manager will review the audit logs for any trends or patterns. Problem areas will be reviewed at the Quality Assurance meeting held at least on a Quarterly basis.	